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Patients' Perceptions of Mental Illness: Paradigms for Analysis*

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The patient's perspective of mental illness is a topic that has heretofore been accorded only passing concern by social scientists. In this paper, data from an investigation of mental patients' perceptions of the causes of their illness are presented and four paradigms developed for the interpretation of these data. The Taxonomic Method is a procedure for classifying the motley replies patients give into categories denoting problem areas. *In the Medical Model emphasis is placed on the gamut of* psychiatric symptoms *patients call forth in their explanations. The defining categories of the Behavioral Model, rather than represent different types of problems or symptomatology, symbolize configurations of* behavioral deviations *from normative standards. A fourth means of interpreting patients' views is the Motivational Approach, whereby consideration is given to the motives or rationales behind the replies and categories consist of various* linguistic devices. *Methodological problems involved in the utilization of these models are discussed and several theoretical perspectives for empirical analysis are suggested.*

SCANT attention has generally been given in the social psychiatric literature to mental patients' perceptions of the etiology of their illness. While a number of different themes have been investigated quite adequately—e.g., the epidemiology of mental disorders, the prevalence of psychiatric symptoms among community residents, mobility patterns of disturbed persons, and the mental hospital as a social system—relatively few social scientists have considered the patient's perspective of mental illness. Goffman (1961:150–154), in his seminal essay on the moral career of mental patients, touches upon their use of the "apologia," a defensive line concerning self; patients' apologias are not analyzed *per se* but rather interpreted in terms of the degrading aspects of mental institutions that often belie these fabricated stories. Similarly, Sampson et al. (1967:72–116) make some attempt to understand the patient's definition of illness with regard to the different factors that led to hospitalization. Several other reports have also appeared (Redlich et al., 1955; Williams, 1957; Langley, 1963; Jones et al., 1963; Grey, 1966).

It is difficult to assess exactly why there have not been more endeavors to enter the world of mental patients and understand how they interpret their illness and present social condition. Perhaps this is the result both of a theoretical bias and of an empirical shortcoming. In the former case, social scientists, if they have tacitly assumed the psychiatric definition of the situation, may not have deemed patients' views a subject of intrinsic value. From this perspective (American Psychiatric Association, 1968:14–52) mentally ill persons are believed to possess some kind of psychopathology (thought malfunctions, disturbances in mood or emotion, personality defects, or character disorders) and are expected to exhibit various symptomatology (hallucinations, delusions, mood swings, anxieties, or maladaptive behavior patterns). If this impression is correct, testing patients on their conceptualizations of illness would therefore be a futile exercise, since their responses are assumed to be unreliable or irrelevant. In the latter instance, the lack of paradigms suitable for the interpretation of data of this kind may have discouraged prospective re-

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searchers. For example, Schatzman and Strauss (1966) suggest five different approaches to the study of psychiatry, Manis (1968) describes seven alternative perspectives keyed to community mental health research, and Taber et al. (1969) propose five models that focus on the definition of mental illness. None of the schemes offered by these investigators, however, appears wholly fitting for research on patients' ideas of illness, although some are useful as general orientations.

The present paper is concerned with these current problems: the relatively meager data extant dealing with the patient's perspective of mental illness and the absence of social psychiatric frameworks necessary for the analysis of these data. Our attentions, therefore, are directed in the following three areas.

First, data from a study of mental patients (Weinstein, 1968) are presented and an empirical paradigm (the Taxonomic Method) is developed for the interpretation of the diverse responses given as causes of illness. The general categories of this model are outlined, along with the criteria for classification and some specific examples. A second problem considered is the creation of three alternative paradigms (the Medical Model, the Behavioral Model, and the Motivational Approach) which can be used to categorize patients' replies. Here, the defining characteristics are more abstract and theoretical in nature but they nevertheless have empirical bases. The orientations of these three schemata are consistent with general theories from psychiatry, sociology, and social psychology, respectively, and categories are created so that the entire range of answers given by mental patients according to the Taxonomic Method can be reinterpreted and restructured to coincide with the new criteria. Finally, a third focal point is concerned with the methodological problems inherent in the application of these four paradigms and some theoretical perspectives that might be adopted.

It is hoped that social scientists will be alerted to the importance of studying patients' attitudes toward mental illness and stimulated to conduct research on this topic by the material presented in this report.

Empirically Derived Categories

The patient protocols quoted here were gathered at Camarillo State Hospital, Camarillo, California. A sample of more than 500 adult psychiatric patients either completed a questionnaire on their perceptions of the etiology of their illness or were interviewed directly. For the purposes at hand, the most important part to the schedule is an open-ended question. Patients were asked what they feel the main causes of their illness are and were required to present explanations for their choices as well. They were free to respond in any manner they chose and many patients listed more than one etiological factor while others claimed they were not mentally ill or did not know what caused their illness. Quantitative findings and a more comprehensive treatment of the study's methodology can be found in Weinstein and Brill (1971a, b). The data are examined from a qualitative standpoint only in this conceptual paper.

The Taxonomic Method. The most conventional method of interpreting patients' perceptions of etiology is to classify the different responses according to their generic content. This procedure is taxonomic and yields certain problem areas as groups of causative factors. Concern is given only to the substantive aspects of the replies and not to any abstract psychiatric, behavioral, or motivational phenomena that they may represent. Following this line of reasoning ten general categories were derived empirically from an analysis of the data and comprise the Taxonomic Method. This system of classification is very similar to those developed by other researchers in their studies of public attitudes toward the causes of mental disorder (e.g., Ramsey and Seipp, 1948; Cumming and Cumming, 1957:66–67).

The category *Economic Problems* is used for all patients who somehow link their mental illness to poverty, material deprivations, financial worries, or occupational difficulties. Patients in higher social classes as well as lower give various economic factors as causes of their illness. *Social Problems* refers to environmental circumstances, negative social characteris-

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tics, and behavioral problems, such as loneliness, lack of friends, stigmas, antisocial activities, and neighborhood concerns. The unique social difficulties cited by a 32-year-old female schizophrenic to explain her illness are worth noting:

> Since my parents were deaf mutes, I grew up in a home different than most others. I was quiet and withdrawn as a child and had few friends. I wasn't allowed to show much feelings of temper and even if I did no one could hear me.

A wide variety of psychological conflicts that patients report can be grouped under *Personal Problems*. Many are in relation to self (personal inadequacies or character flaws), some deal with other people (shyness, rejection, jealousy), while still others are of a sexual nature. *Emotional Symptoms* is used for patients who believe emotional factors or psychiatric symptoms caused their illness, e.g., depression, anxiety, emotional deprivation, nervousness, mental confusion, hallucinations, or delusions. Those that talk about emotions or symptoms in terms of social, personal, or other problems should be placed in these latter categories. In *Family Problems* we find patients who claim difficulties with particular family members or their family in general. Different kinds of problems are often given, such as "mother made me feel inadequate," "had to take care of mother and couldn't do what I wanted," and "mother coddled me." Several patients said that the strain of caring for someone else in the family who was mentally ill or continually visiting mental hospitals was responsible for their own nervous breakdown. As the title implies, *Somatic Disorders* is a category for responses that suggest real or imagined hereditary or physiological disorders. Physical disabilities often seriously tax a person's emotional strength, although they may not contribute to mental illness directly, as is evident from the reply of a young female neurotic:

> I have a fractured disc in my back and it causes me quite a lot of pain and makes me awfully nervous.

Patients implying that a particular event or circumstance was a great shock to them are placed in *Traumatic Events*. Some examples of these are death of a loved one, divorce, separation, and rape. In general, patients classed in *Religious Problems* appear to conceptualize these difficulties in diverse terms, i.e., they tend to say that either "too much religion" or a "lack of religious background" is responsible for their illness. The category *Drugs and Alcohol* is used for patients who feel the excessive or inappropriate use of these addictives caused their mental disorder. Patients with a diagnosis of sociopathic personality disturbance (drug or alcoholic addiction types) often give answers that fall under this heading. However, those discussing the implications behind the use of drugs or alcohol—as in family breakups, traumatic events, or social hardships—should be classified in the group appropriate for these responses. Patients replying to the open-ended question on etiology in a manner that suggests no substantive category can be placed in *Miscellaneous Replies*. Here we find those that refuse to answer, give unintelligible or incomprehensible or nonsensical replies, claim they are not mentally ill, or simply have no idea at all what the causes of their illness are. Sometimes, however, patients purport they are not ill or that they do not belong in the mental hospital and then go on to explain the circumstances surrounding their institutionalization. For example, a 36-year-old unmarried female manic-depressive related the following story:

> I do not feel I am mentally ill. If anything, I'd classify it as emotionally ill and mentally misunderstood, because I am a square peg fitting in a round hole. A friend of mine, a Negro artist, broke into my apartment. The police caught him in time to save my life. I was advised to commit him, but I didn't, whereupon they committed me instead.

Alternative Paradigms

Blumer (1956:686) has called the attention of sociologists to the "process of interpretation" in human group life (the way people define objects, events, and situations) and advised them to consider it in their analyses. Similarly, Denzin (1970:7–

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10) maintains that the investigator must perceive human conduct from the point of view of those he is studying and connect man's conceptions of self with the broader social structures that give rise to these conceptions.

These methodological principles are important for the study of the patient's perspective of mental illness. The categories of the Taxonomic Method are "common sense" groupings for causes of mental disorder and offer the social scientist a traditional frame of reference. However, the wider implications of the data cannot be uncovered by use of this model alone. Hence it is the purpose of this section to suggest and outline three alternative paradigms, each one focusing on a different interpretive process patients go through in defining their illness or explaining their hospitalization. The use of these models ventures to "take the role" of the mental patient and comprehend his conceptions of self.

At this juncture, we may ask two questions: (1) what elements of culture or social structure impinge upon mental patients and affect their perceptions of illness? and (2) can these phenomena be generalized into different paradigms and new categories created for patients' sundry explanations? We suggest three such instances whereby these questions can be answered meaningfully. First, it is clear that patients are influenced by the medical process of mental illness and hospitalization (Goffman, 1961; Weinstein and Brill, 1971a) and thus psychiatry offers us one new perspective. As mental illness involves deviations from normative standards and patients are affected by their own behavior and the reaction to it by others (Scheff, 1966:31–54), we can look to sociology for a second alternative paradigm. Still another means of reinterpreting the replies is to consider patients' search for motives or apologias to explain their social situation (Goffman, 1961:150–154) and some general theories of social psychology are useful.

The Medical Model. A paradigm for persons who conceptualize mental illness along strictly psychiatric lines or for those who wish to interpret patients' explanations for their illness in terms of psychiatic symptomatology is the Medical Model. The medical perspective of mental disorders, which assumes that patients' observed symptoms are manifestations of some underlying psychopathology, forms the basis of this paradigm. Disease or clinical entities associated with particular psychiatric symptoms essentially comprise the different categories and social scientists favoring this framework would evaluate patients' beliefs about their illness according to the type of mental disorder they represent. The general scheme of this paradigm is consistent with the medical perspective for sociological research suggested by Manis (1968:500) and the disease model in psychiatry criticized by Taber et al. (1969: 350–352). However, the nine categories and criteria for classification of the Medical Model parallel actual mental disorders and conform to the diagnostic nomenclature established by the American Psychiatric Association (1968:14–52). Some changes were effected by combining, separating, or omitting particular diagnostic classes in order to suit them more concretely to the data.

Patients believing biological, hereditary, or physical disorders caused their mental illness should be grouped under *Organic Problems.* This category reflects disease entities such as mental retardation, organic brain syndromes, and psychophysiologic disorders. *Schizophrenic Symptoms* portrays a major mental illness, schizophrenia, which literally means a "splitting" of the psychic functions. Replies suggestive of a distortion of mental processes or unrealistic thinking on the part of the patient (hallucinations, delusions, illusions, hostile or aggressive behavior, silly or regressive actions) would all be placed here. The feelings of a 34-year-old male paranoid schizophrenic concerning the causes of his illness are a good example of this kind of symptomatology:

> I am afraid of rejection and afraid of criminal attack of some kind. I feel people won't give me a chance, and something has been spread around against me to make people dislike me. My friends accused me of things I didn't do, and I feel

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that people I don't know want to hurt me in some way.

Affective Disorders mainly comprises the manic-depressive psychoses and involutional melancholia. Persons with these illnesses have a severe disturbance in their mood or emotions, and the affect is out of proportion with objective circumstances. Patients claiming depression, elation, mood swings, or other similar emotional factors caused their illness would fall in here. Those grouped under *Neurotic Reactions,* by contrast, are the ones who explain their illness in terms of subjective anxiety or a sense of distress, such as fears, obsessions, uncontrollable impulses, extreme uneasiness, anxieties, etc. These are the symptoms associated with different types of neurotic disorders. The category *Personality Disorders* also represents several different types, but here emphasis is on pathological traits or developmental defects in the personality structure. Patient replies suggesting disorders of character or disposition (hypersensitivity, rigidity, jealousy, insecurity, eccentricity) are all relevant here. Consider the response of a 23-year-old female schizophrenic:

I am not self-confident because I don't feel or act maturely. I am easily swayed and pick up idiosyncrasies of others just to be accepted or prove a friendship. I lose my identity and, knowing this at the time, even I myself become angry.

In *Sociopathic Deviations* we find chiefly three types, the alcoholic, the drug addict, and the sexual deviate. Patients explaining their illness in terms of the recognizable symptoms of sociopathic personality disorders should be classed here. *Childhood Behavior Disorders* should be used for patients, irrespective of age, linking behavioral difficulties of childhood or adolescence to their mental illness (e.g., sleeplessness, nightmares, lying, delinquency, destructiveness). *Latent Psychiatric Disorders* refers to social maladjustments without manifest psychiatric impairment. Patients reporting various economic, social, family, and other difficulties not clearly identified with the symptoms of mental illness would belong here. The category *Miscellaneous Replies* has the same criteria as in the Taxonomic Method.

The Behavioral Model. A paradigm in direct opposition to the Medical Model is the Behavioral Model. In this case the focus is the sociocultural perspective of mental illness, rather than the psychiatric, and the accent is on the degree and kind of behavioral deviations from normative standards that ill persons often engage in. Sociologists have generally questioned the medical model of illness and have perceived the symptoms of mental disorder, rather than indicative of some pathological condition of the individual, as expressive of aberrations of conduct which are neither approved nor intelligible to people in the community (Faris, 1955:324; Erickson, 1957:264; Clinard, 1957:17–18). Lemert (1951:390) makes use of his concept of "societal reaction" to explain mental illness. A person is labeled as mentally ill when his behavior is inconsistent with the socially objective estimates of his role and status. Similarly, Scheff (1966:31–54) has argued that mental illness is "residual deviance." Society, in his view, has names for most kinds of norm violations (e.g., bad manners, delinquency, sexual perversion) but there are no labels for deviant activities not clearly understood by others, such as the behavior often attending psychiatric symptomatology, and therefore the category of mental illness is used.

The Behavioral Model makes use of the theories of these and other sociologists but is not a function of any one of them. The seven major categories were conceived and are designed to represent a continuum of behavioral deviations along two coterminous dimensions of the sociocultural view of mental illness, the "seriousness" of the the deviations and their "intelligibility" to others in light of community norms. In developing this paradigm as a frame of reference within which to interpret patients' views of illness, typologies were not called upon. There is no formal set of categories in the sociological literature that analytically define, in a general sense, different kinds of deviant behavior (Lofland, 1969: 25–26). All that exist are such phenomenological groupings as suicide, alcoholism,

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crime, or mental illness, but none that "cut across" these categories. The typology of deviant types by Merton (1938) and the directions of deviant orientation by Parsons (1951:256–267) are not suitable for our purposes.

Since this model uses the individual's behavior as its criterion, it was believed best to subdivide the miscellaneous replies of the previous two paradigms. The category *No Deviation,* therefore, only includes those patients who claim they are not mentally ill or refuse to answer questions concerning their illness, while *Unknown Origins* is for those who admit to illness (and deviation) but who are at a loss concerning its etiology or present incomprehensible replies. *Normal Occurrences* should be used for patients who point to various phenomena as causes of their illness which do not reflect any deviant behavior on their part, but rather are normal everyday happenings seemingly unrelated to mental disorder. Poverty, environmental circumstances, deaths in the family, and organic problems are examples of such occurrences. Replies indicative of minor deviations in conduct which are intelligible to most people and perhaps suggestive of nascent psychopathology (marital conflicts, family problems, occupational difficulties, interpersonal problems) would qualify for inclusion under *Behavioral Problems.* The category *Normative Deviations* is for behavioral deviations from normative standards which are disapproved of more and are somewhat less understandable than those in the previous group, such as alcoholism, religious conflicts, and antisocial activities. It is also used to classify psychic or personal deviations from normative standards (emotional difficulties, psychological disorders, negative social characteristics) which often entail behavioral abnormalities as well. *Moral Deviations* is reserved for very serious behavioral abberrations, those which violate mores rather than norms and which are even less intelligible to society. Patients perceiving the causes of their illness within the context of drug abuse, sexual deviations, or criminal behavior should be included here. For example, a 19-year-old single girl, with a sociopathic personality disturbance (drug addiction type), expressed her views on her illness candidly and painted a lurid picture of her moral deviations:

> The drugs I had stimulated my sexual desires. When I got pregnant, I wanted to stay home with my mother but she was never there. She was out making love with other men. So I drank. Then my mother sent me to live with my dad. That's why I drink and take drugs and sleep with hippies. Because it is fun. When I'm doing these three things, they accept me. Otherwise I'm very shy and nervous.

Finally, *Residual Deviations* represents completely unintelligible behavior, that which is disapproved of very strongly and is recognized clearly as symptomatic of mental disorder. In this category would be placed replies suggesting hallucinations, delusions, silly behavior, or bizarre actions on the part of the patient. A 33-year-old married woman, with a diagnosis of chronic brain syndrome associated with alcoholism, spoke strangely about her deviant behavior and causes of her illness:

> I went to a psychiatrist regarding my drinking too much. He suggested I try marijuana and I did. Within three sessions, this led me to stop drinking. I resolved my sexual problems, gained complete religious insight, and became a truly happy individual.

The Motivational Approach. The fourth paradigm introduced in this paper is the Motivational Approach. Students of social psychology might especially look with favor upon this model, which has as its underpinning the variety of abstract motives and verbal rationalizations behind patients' explanations for mental illness. This paradigm is an outgrowth of material dealing with the sociology of motivation, which dates back to Max Weber. Parsons (1949: 642) notes that Weber conceptualized motives in terms of their social character, as causal interpretations of social action that appear adequate or understandable to the actor and/or the observer. Mills (1940) believed the slew of reasons given for behavior are themselves not without reasons and initiated the concept of "vocabularies of motive," the lingual terminologies per-

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sons engage to explain their actions. More recently, Scott and Lyman (1968:47) developed the idea of "acounts," the linguistic devices or verbal stratagems mouthed to explain untoward behavior; excuses are accounts by individuals who recognize that their actions are deviant but deny full responsibility for them, while justifications are accounts by those who accept responsibility for their behavior but disclaim the pejorative quality associated with it. Blum and McHugh (1971), in addition, have described the social structure and organization of motives.

The eight categories and defining characteristics of the Motivational Approach are given below. Fundamentally, they compose the entire gamut of motives and verbal patterns espoused by patients to account for their mental illness. This paradigm draws rather heavily on the typology of excuses outlined by Scott and Lyman (1968:47–51) but is not coincident to it, as some changes were necessary. It is obvious from material presented thus far in the paper that patients endeavor to excuse their illness by shifting the blame to other people, adverse experiences, or inauspicious personal qualities. From the more than 500 replies of this study we cannot recall a single instance whereby a patient rejected the notion that mental illness involves negative properties and then attempted to justify his commitment. The theories of Goffman (1961:125–169) regarding mental hospitalization and defensive lines from patients also play a role in the formulation of the Motivational Approach.

The categories *Denial of Illness* and *Unknown Origins* correspond exactly in criteria to the first two in the Behavioral Model. Only the titles of the first category in both paradigms vary to reflect more adequately the particular frames of reference involved. *Appeal to Accidents* should be used for patients who explain their mental illness by charging that accidental or contingent factors led to their institutionalization. Those that claim they were sent to the hospital because of difficulties with the police, drunkenness, or illegal use or possession of drugs especially qualify for inclusion here. Patients grouped under *Appeal to Psychic States* believe their illness is due to emotional disorders, personality traits, or psychiatric symptoms. This category has the underlying criterion that replies be suggestive of defeasibility. The response of a young female schizophrenic is illustrative of a reference to various psychological factors that suggest the illness could have been avoided:

> I couldn't develop much of an ego while growing up. I feel worthless because of the lack of proper affection and attention in my childhood. I was constantly rejected up until the age of 19. I had five sets of parents, guardians, and foster parents, and lived in children's homes. This is the main cause of my illness I feel.

Appeal to Biological Forces, by contrast, has an overriding element of fatalism in it. Patients apologizing for their illness by reference to hereditary, biological, or physical disorders largely intimate that it could not have been avoided. *Scapegoating,* refers to a motivational technique whereby some other person or persons is held responsible for one's illness. Parental difficulties, marital conflicts, heterosexual or romantic problems, and death of a loved one are all examples of scapegoating pleas. Sometimes, however, they are verbalized with ironic twists, as in the case of a 21-year-old female schizophrenic. This particular patient blamed her illness on her husband and daily sexual demands but also declared that she had been sexually promiscuous before being committed and since has engaged in "bush therapy" with other patients, illicit sex relations on the hospital grounds. *Unfortunate Circumstances* is a category for those who echo various situational factors or external events as causes of their illness, such as economic problems, negative social attributes, environmental hardships, and death or divorce in general. Patients fabricating stories with a network of interrelated etiological elements, perhaps in an effort to gain sympathy from the observer, may be placed in *Sad Tales*. Two examples from the data depicting a combination of different factors should suffice. A 58-year-old female schizophrenic, divorced from her husband, complained:

> I worked a split shift for eight years and never finished meals. I worked six days a

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week and did my own housework too. My first husband got killed on his job. The shock was too much for me. All three things—overwork, mental strain, and loss of a loved one—made me have colitis and a nervous breakdown.

A 26-year-old single girl suffering from schizophrenia told another sad tale:

I have bad eyesight and things get blurry, but I can't use glasses. I can't drive too well and often get tired on my job. I didn't like my jobs as a secretary and sales clerk but I did it to make a living. I also get depressed at times. I didn't get along well at home either and my parents didn't approve of the way I lived.

Theoretical and Methodological Considerations

Investigators choosing one or more of these models should be cognizant of the different methodological problems inherent in their application. The first problem likely to be encountered is that of coding. Patients often respond to the open-ended question by presenting more than one main cause for their mental illness. Users of these paradigms, therefore, must decide whether to code the replies in terms of "responses" or "people." Patients offering two or more causes which are classed in the same general category are counted only once if the latter method is adopted, whereas each different reply is considered if the former procedure is used. The data justifiably may be coded according to either technique. Another important consideration is the reliability of the coding methods. Several different coders should be used and each may be required to classify the same material on more than one occasion. The categorization of patients' replies should not be vexed with interpretive discrepancies on the part of the investigator.

A third point worth noting is the flexibility of each of the four paradigms. Particular categories may be added, deleted, modified slightly, or change substantially in order to suit them better to the data at hand. Although the general categories of each paradigm represent a complete classificatory schema according to the author's data, alterations by other researchers may be necessary. Besides this quality of flexibility in each model is the concomitant notion of a lack of interchangeablitiy of categories. The four paradigms are mutually independent of one another. Each has its own unique orientation and a set of categories in which to group patients' replies that are not interchangeable and should not be combined to form some hybrid paradigm.

A final methodological issue of some importance is one of data analysis. Each model may be used alone or in conjunction with one or more of the others. In the former case statistical techniques may be applied so that social, demographic, or psychiatric variables are cross-tabulated with different categories of a particular model. Data analysis of this kind is useful for determining which groups of mental patients employ certain explanatory factors more frequently than others. In the latter instance, categories of different models may be intercorrelated and degrees of correspondence sought between two or more paradigms.

In addition to these technical problems that should be considered, social scientists concerned with studying mental patients' perceptions of illness would be wise to adopt a meaningful theoretical perspective and then apply one or more of these models in appropriate fashion. Mechanic (1968: 52–85) has outlined and described four such frames or reference in the field of medical sociology that would be helpful to future researchers. In the cultural perspective emphasis is placed on the cultural variations between different groups in society regarding perception of symptoms and illness. Those entertaining this framework would explore, for example, ethnic, racial, or religious differences in patients' perceptions and seek the cultural bases for varying conceptualizations. By contrast, the social perspective pertains to the host of environmental factors and interpersonal experiences from the social structure that may influence patients' views. Some variables that might be considered include: social class, occupation, marital status, age, and sex. A theoretical orientation that embraces several disciplines and fields of interest is the social psychological, psycho-

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analytical theories, socialization processes, symbolic interaction, and ethnomethodology all have relevance here. Finally, the societal perspective is concerned with the way social institutions treat illness as well as society's response to mental patients and disordered behavior. Theories of role behavior, the sick role, societal reaction, and labeling offer the investigator fruitful starting points.

Concluding Remarks

In conclusion, it is appropriate to comment on the possible therapeutic and clinical importance of the material presented in this paper. Psychiatrists, psychologists, social workers, and other health professionals may find these four paradigms useful. King (1962:135), for example, believes that those concerned with the treatment and prevention of mental disorders can deal more effectively with patients and their families if they understand how illness is perceived. Our models, therefore, may serve a dual function. They offer research scientists opportunities to contribute to social or psychological theory as well as provide clinical personnel with some essential tools with which to delve more deeply into their patients' beliefs and attitudes about mental disorder.

Much of psychiatric practice falls within the purview of psychodynamically oriented therapists, those who focus on intrapsychic conflicts and developmental defects in personality, and practitioners that concentrate on the use of organic methods for the rehabilitation of the mentally ill. In either case, too little attention is often paid to the patient's own assessment of illness and to the environmental factors that led to his social impairment. Mechanic (1968:433–437) has argued that an over emphasis on traditional psychiatric methods may be quite costly and relatively ineffective; intervention in the patient's social environment and attempts to change the conditions that led to illness is perhaps a more realistic alternative. It would appear then that clinical or therapeutic use of these paradigms might assist those in the mental health professions in exploring patients' life difficulties, interpersonal relationships, or conceptions of self and illness.

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Correlates of the Psychiatric Sick Role*

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This study analyzes a number of social, psychological, and social-psychological factors in relationship to a patient's acceptance or rejection of the psychiatric sick role (PSR). A stepwise regression analysis revealed that the most important factor in PSR scores was whether or not the patients saw their therapists as significant others. PSR scores were also influenced by the patients' concept of mental patients, referral for treatment by community gatekeepers, the number of times psychiatric treatment was sought, socioeconomic class, and the amount of time spent in nonpsychiatric detention (as in delinquent detention).

PARSON'S (1951) conceptualization of the sick role has now been researched for twenty years. During this period a number of findings have qualified the original formulation, which included two rights and two obligations. For example, we have learned that the evaluation of illness symptoms and taking the appropriate action to relieve the symptoms are mediated by a number of social, cultural, and psychological factors. A sampling includes education (Koos, 1954), social class (Rosenblatt and Suchman, 1964), the cost of care and the ability to pay for it (Gurin, 1960), "other" role responsibilities (Mechanic, 1959), fear of discovering a serious

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